TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Texas Health Huguley

Respondent Name
Bridgefield Casualty Insurance Co

MFDR Tracking Number
M4-25-0135-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 25, 2024	70450	$61.95	$0.00
January 25, 2024	74177	$330.73	$0.00
January 25, 2024	71260	$170.36	$0.00
January 25, 2024	72125	$58.90	$0.00
	Total	$621.94	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "Per the received EOB, CPT codes 70450, 74177, 71260 and 72125 were not paid correctly per TX work comp fee schedule."

Amount in Dispute: $621.94

Respondent's Position

"In conclusion, Respondent has paid for each service in dispute at the fee guideline amount."

Response submitted by: Downs ♦ Stanford, P.C.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the rules and fee guidelines of outpatient hospital services.

Denial Reasons

- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 630 - This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- A12 – Reconsideration of disputed claim.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What rules(s) are applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of codes 70450, 74177, 71260 and 72125. These CT scans were adjudicated, and a payment was made by the insurance carrier.

   DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

   The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants is not applicable.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 70450, 74177, 71260, and 72125 have a status indicator Q3, for conditionally packaged codes paid as a composite. This composite is assigned APC 8006. The OPPS Addendum A rate is $428.04. This is multiplied by 60% for an unadjusted labor amount of $256.82, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of $240.95.

     The non-labor portion is 40% of the APC rate, or $171.22.

     The sum of the labor and non-labor portions is $412.17.

     The Medicare facility specific amount is $412.17 multiplied by 200% for a MAR of $824.34.

- The requestor billed the procedure code 99285 which is not in dispute, however, to determine proper reimbursement, the following applies to this charge. Procedure code 99285 has status indicator J2 when an 8 or more hours observation billed. Review of the submitted medical bill found observation hours were not billed. This code is assigned APC 5025 with a status indicator of V. The OPPS Addendum A rate is $611.99 multiplied by 60% for an unadjusted labor amount of $367.19, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of $344.50.

  The non-labor portion is 40% of the APC rate, or $244.80.

  The sum of the labor and non-labor portions is $589.30.

  The Medicare facility specific amount is $589.30 multiplied by 200% for a MAR of $1,178.60.

3. The total recommended reimbursement for the disputed services is $2,002.94. The insurance carrier paid $4,602.97. Additional payment is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		January 10, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field

office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.